

Case Number:	CM14-0005699		
Date Assigned:	02/05/2014	Date of Injury:	05/21/2012
Decision Date:	06/20/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgeon, Sports Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The mechanism of injury was not provided for review. The injured worker was treated conservatively with medications, physical therapy and activity of restrictions and underwent a right-sided discectomy at the L5-S1 on 11/12/2012. The injured worker had residual pain complaints. The injured worker underwent an MRI on 05/30/2013. It was noted there was no significant change in the mild posterior disc protrusion at the L4-5 space with no evidence of significant spinal canal stenosis or neural foraminal stenosis. There was noted there was a marked decrease in the degree of the right par central disc protrusion of the L5-S1, less effacement at the anterior thecal sac and minimal right neural foraminal narrowing. The injured worker was evaluated on 12/05/2013. It was documented that the injured worker had -4/5 decreased motor strength in right dorsiflexion, an absent reflex in the right ankle, a positive straight leg raising test at 40 degrees on the right and diminished sensation over the lateral shin and anterior foot of the right lower extremity. The injured worker's diagnoses included lumbar disc herniation and lumbar radiculopathy. The injured worker's treatment plan included a discectomy and facetectomy revision of the right L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

L5-S1 TRANSFORAMINAL LUMBAR INTERBODY FUSION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The requested L5-S1 transforaminal lumbar interbody fusion is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention when there are clear physical findings supported by an imaging study that would benefit from surgical intervention. The clinical documentation submitted for review does indicate that the injured worker has radicular symptoms. However, the injured worker's most recent imaging study does indicate that the disc bulge at the L5-S1 decreased with less effacement of the adjacent anterior thecal sac. The American College of Occupational and Environmental Medicine recommends fusion surgery for injured workers who have evidence of instability. The injured worker does not have any evidence of instability pre-operatively but given the planned surgery, with removal of the residual disc and at least 50 percent of the facets, the segment will be by definition unstable. Thus, the fusion for the requested fusion would be standard as part of the planned procedure. As such, the requested L5-S1 transforaminal lumbar interbody fusion is medically necessary and appropriate.

3 DAY INPATIENT STAY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hospital Length of Stay

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hospital Length of Stay

Decision rationale: The requested bone growth stimulator is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of bone growth stimulators unless there is evidence of non-fusion, surgical planning of a multi-level fusion, or that the patient is at risk for non-fusion. The clinical documentation does not support that the patient is at risk for non-fusion and the planned surgical procedure is for one level. As such, the requested bone growth stimulator is not medically necessary or appropriate.

ASSISTANT SURGEON: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Surgical Assistant

Decision rationale: The request for the surgical assistant is medically necessary and appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do recommend a surgical assistant for complex surgeries such as spinal fusion. As such, the requested assistant surgeon is medically necessary and appropriate.

■■■■ LSO LUMBAR BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Back brace, post operative (fusion)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Back brace, post operative (fusion)

Decision rationale: The requested ■■■■ LSO Lumbar Brace is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of post-operative bracing for single level fusion surgeries. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested ■■■■ LSO Lumbar Brace is not medically necessary or appropriate.

PURCHASE OF EXTERNAL BONE GROWTH STIMULATOR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

Decision rationale: The requested bone growth stimulator is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of bone growth stimulators unless there is evidence of non-fusion, surgical planning of a multi-level fusion, or that the patient is at risk for non-fusion. The clinical documentation does not support that the patient is at risk for non-fusion and the planned surgical procedure is for one level. As such, the requested bone growth stimulator is not medically necessary or appropriate.